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	AF0460A	A. BUILDING _____ B. WING _____	01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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B1085 SS=J	1001.15 (f) (1) Inspection and Enforcement (f) Schedule of Penalties. (1) Civil penalties for licensed assisted living residences. Civil penalties of up to $1,000 per day may be assessed against assisted living residences, except those operated by a social services district, for violation of these regulations or of an order pursuant to subdivision (8) of section 460-d of the Social Services Law. This LICENSURE is not met as evidenced by: Based on a review of one resident record, facility records, ambulance records, police records, hospital records and interviews with facility residents and staff during the complaint inspection initiated on 12/11/17 and completed on 1/10/18, it was determined the operator failed to provide adequate and sufficient supervision services as required by Regulation 487.7(d)(1)(i), maintaining knowledge of the general whereabouts of each resident; Regulation 487.7(d)(1)(v), surveillance of the grounds, facility and activities of residents to protect residents from harm to person or property; Regulation 487.7(d)(1)(vi), monitoring emergency call systems within the facility; Regulation 1001.10(g)(1), designate sufficient staff who shall be responsible for monitoring residents on-site; Regulation 1001.10(g)(2)(i-ii), provide monitoring at any hour of day or night to respond to urgent or emergency needs to the extent that residents were endangered, as evidenced by the following: The facility is licensed and certified for 200 ALR/EALR beds including 20 SNALR beds in a secure dementia unit. The resident rooms are separated into 5 units. The older portion of the building houses units East 1 (first floor) and East	B1085	A Manager on Duty is assigned and in the building 24/7 to supervise staff, serve as a point of contact and make rounds throughout the building. A tool that contains the duties of the Manager on Duty has been developed and uploaded for review. Appropriate staffing plans have been implemented and uploaded. Revisions to the staffing will be made based on the need of occupancy and level of resident care. A list of Enhanced residents to include care needs has been provided. The following documents have been attached to support this: 1. Manager on Duty 2. Master Staffing Plan 3. Brompton Heights Enhanced Resident Care Summary 4. Enhanced Assisted Living Summary Person Responsible: Director of Personal Care, Assistant Director of Personal Care, and Administrator Policies on Roam Alert System, Procedure for Missing Resident Incident and Perimeter Exit Door Alarm were reviewed and revised. Employees have been educated on the above policies. A policy on Monitoring of Residents was developed and on-going education will continue. These polices have been added to the on-boarding and orientation paperwork for new employees. The schedule of in-services for 2018 has been included. The following documents have been	03/19/2018

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B1085	Continued From page 1 2 (second floor). The North unit, South unit and the dementia unit are located in the newer section of the building and are separated from the older units by common areas including the lobby, main dining room, activity rooms and administrative offices. The facility is equipped with interior and exterior cameras, an emergency call bell system that includes door alarms and a Roam Alert monitoring system for use with specific residents that have been identified with potentially unsafe wandering behaviors. On [redacted]17, resident #1 was admitted to the Enhanced Assisted Living Residence (EALR) with diagnoses of [redacted] with [redacted] and [redacted] The [redacted]17 pre-admission evaluation indicated the resident was incontinent of urine several times a day, incontinent of bowel several times a week, required assistance with eating, ambulation, transferring, toileting, bathing and dressing. The cognitive screen indicated the resident had [redacted]n orientation, memory and alertness. Facility staff reported that the resident was only oriented to person and place. Facility assessments indicated the resident was a [redacted]risk for wandering and a [redacted]risk for falling; however, the facility had not utilized the roam alert system for the resident. The resident resided on East 2 unit. Employee # 1, the facility aide assigned to East 2, reported to Department staff that on [redacted]17 at approximately [redacted] during rounds, he provided toileting assistance to resident #1 and that this was the last time he observed this resident in the building during the overnight shift (11:00 p.m. - 7:00 a.m.).	B1085	attached to support this: 5. Roam Alert System 6. Procedure for Missing Resident Incident 7. Perimeter Exit Door Alarm 8. In-servicing Roster for Roam Alert System, Procedure for Missing Resident Incident, Perimeter Exit Alarm (sign-in sheets will be available upon request) 9. Monitoring of Residents 10. Brompton Heights Schedule of In-Services 2018 Person Responsible: Department Managers and Administrator The Perimeter Exit Door Alarm on the nurse call bell system was upgraded from a wall switch shut off to a key shut off. The Director of Maintenance and the Administrator are the only personnel with access to this key. In addition, the reset button can only be accessed with a key available to the administrator and the manager on duty. This action can only be done after all residents are accounted for. There is no "manufacturer" or "vendor" for this improvement, as it was completed independently by the Director of Maintenance. Person Responsible: Director of Maintenance and Administrator Attached is a letter that went out to all staff in December 2017 specifying that breaks are not to be combined with meals and that employees are not permitted to leave the building during break on overnight shifts. This was reiterated at the all staff meetings on 1/4/2018 and 2/9/2018. Attendance	

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B1085	Continued From page 2 Employee #1 stated that at approximately [redacted] on [redacted]17, he had combined his lunch and two 15 minute breaks and went to a lounge and was sleeping for approximately one hour until [redacted] Other facility staff confirmed that employee #1 was often sleeping during his shift. On [redacted]17 at [redacted], resident #1 was observed on a facility camera walking past the East 2 unit nursing station wearing [redacted] At approximately [redacted], facility records indicated that the [redacted] Door [redacted] alarm was activated. Facility records showed that the door was open for 36 seconds. When a door alarm is activated, it alarms/rings at all 5 nursing stations throughout the facility. Therefore, all staff throughout the facility are notified by the alarm sounding at the nurse's station that a door alarm has been activated even if it is not on their assigned unit. At [redacted], three staff members, employee #2, the medication aide assigned to East 1 and 2, employee #3, the facility aide assigned to East 1, and employee #4, the facility aide assigned to the South unit, were observed on a facility camera with their coats on and subsequently leaving the facility through the co-worker entrance. At approximately [redacted] facility records indicated that [redacted] Door [redacted] was opened for 5 seconds. Employee #5, the facility aide assigned to the North unit, reported to Department staff that the door alarm had been going off "for hours" and that she left her assigned unit to "clear off bells" on the East 2 unit including the [redacted] door [redacted] alarm at	B1085	Rosters and Agendas are attached. Managers on duty perform rounds of the building for compliance. The following documents have been attached to support this: 11. Letter to staff December 2017 12. Staff Meeting Agendas and rosters for 1/4/2018 and 2/9/2018 Person Responsible: Manager on Duty and Administrator Quality Assurance Meetings will be held weekly with disciplines of the management team to focus on the quality assurance issues. Rosters and meeting minutes will be available upon request. Person Responsible: Administrator and Department Managers	

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B1085	Continued From page 3 approximately [redacted] Employee #5 was aware of the activation of door alarms and the resident call system because activation of these systems would sound at all 5 nursing stations throughout the facility. During an interview with Department staff, employee #5 stated that at about [redacted] on [redacted]17, she went to the employee lounge where employee #1 was sleeping, and asked employee #1 "do you want me to clear your bells?" Employee #5 then proceeded to the East 2 unit where she found resident #2 [redacted] Employee #5 said that she provided personal care to resident #2 and assisted resident #2 back to bed. Employee #5 told Department staff that she thought resident #2 had set off the door [redacted] alarm. Employee #5 confirmed that she briefly opened and closed door [redacted] and had thought she had reset the door [redacted] alarm and then returned to her assigned unit. Employee #5 confirmed that she did not conduct a room check for other residents at that time. Employees #2, #3 and #4 were observed on a facility camera to have re-entered the facility through the co-worker entrance at [redacted] on [redacted]17. Employees #3, #4 and #5 confirmed that they had left the facility on [redacted]17 at approximately [redacted] for their lunch break (combined with their two fifteen minute breaks) and sat in a car in the facility parking lot. Facility staff reported that they routinely spent their breaks in pairs or groups outside of the building during the overnight shift. Employee #3 confirmed that the facility's emergency call system and door alarms, when activated, could not be heard outside of the building where these employees had been sitting in a vehicle during their break, which was a period of one hour and 8 minutes [redacted] as verified by facility cameras.	B1085		

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B1085	Continued From page 4 Employees #3 and #4 stated that they did not know the location of [redacted] Door [redacted] when the alarm was sounding and confirmed that they did not learn of the location of [redacted] door [redacted] until after the resident was found, more than 3 hours after the door alarm was initially activated. During an interview with the Department employee #1 stated that at approximately [redacted] he realized that resident #1 was not in her room. Employee #1 stated that he searched briefly for resident #1, and then continued to assist other residents with morning care. Employee #1 stated to Department staff that while he heard the door alarm, at that time he did not know the location of [redacted] Door [redacted] At approximately 7:00 a.m., after the Director of Housekeeping and Laundry had arrived for work, facility staff told him that resident #1 was missing. Facility staff called the Personal Care Director at 7:05 a.m. to inform her that resident #1 was missing and she instructed the staff to begin a full building search. At approximately 7:30 a.m., resident #1 was found [redacted] an exterior door which is located at the bottom of a cement stairwell (16 stairs) that leads from the [redacted] Door [redacted] is located at the top of this stairwell. Resident #1 was [redacted] and [redacted] by facility staff into the East 2 unit and taken to an area adjacent to the stairwell in front of an elevator on the second floor. At [redacted], facility staff called 911. The outdoor temperature on the morning of [redacted] 17 was approximately [redacted] degrees and it	B1085		

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B1085	[redacted] [redacted] The resident was transported to the hospital for [redacted] Ambulance records indicated the resident's [redacted] According to hospital records, at [redacted] the resident's [redacted] The resident was admitted to the hospital for [redacted] In an interview with Department staff, another resident that resided on the East 1 unit near the [redacted] stairwell, reported that they had heard [redacted] between [redacted] on [redacted] 17. This resident stated that they activated their call bell, and when a facility staff member responded, the staff member, who was identified as wearing earphones and listening to music, reported to the resident that they did not hear any [redacted] and told this resident that it was [redacted] The resident informed the Department staff that this staff member never removed her earphones to listen for the [redacted] Facility staff confirmed that no further investigation of the [redacted] was made. The location where resident #1 was found was [redacted]	B1085		

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B1085	Continued From page 6 During the overnight shift on [redacted]17 - [redacted]17, the facility census was 127 residents (25 on the East 1 unit, 26 on the East 2 unit, 20 on the South unit, 36 on the North unit and 20 on the dementia unit). The 11:00 p.m. - 7:00 a.m. shift staffing that night included a total of 8 staff, including 2 dementia unit staff that were expected to remain in the secure unit throughout their shift. The facility identified 53 of the 127 residents as requiring enhanced assisted living services, with 34 EALR residents requiring the assistance of one staff for transfers, ambulation and/or toileting assistance, and 3 EALR residents requiring the assistance of two staff for transfers, ambulation, and toileting assistance. In addition, 13 residents had been identified as requiring additional monitoring due to their use of the Roam Alert system. On [redacted]17, from 1:50 a.m. to 5:20 a.m., the East 2 unit was unattended by the assigned facility aide, employee #1. Although employee #1 stated in an interview with Department staff that he had been sleeping on a break from 3:45 a.m. to 4:45 a.m., in fact, employee #1 was observed on facility cameras to have entered the staff lounge on [redacted]17 at approximately 1:50 a.m. and that employee #1 did not leave the staff lounge until approximately 5:20 a.m., thus leaving the East 2 unit unattended for approximately three and one half hours. On [redacted]17, from 4:29 until approximately 5:30, the residents of East 1 and East 2 units were left unattended as one facility aide was confirmed to be asleep and three facility aides were out of the facility, in a car in the parking lot, leaving two staff members available to assist the 107 assisted living residents of which 45 were identified as Enhanced ALR residents requiring	B1085		

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B1085	Continued From page 7 services as identified above, and 13 residents that utilized roam alert due to wandering behaviors. Although employee #1 was suspended and did not work in the facility after [redacted]17, employees #2 and #3 had continued to work at the facility until[redacted]/17, when they were terminated for gross misconduct related to the [redacted]17 incident that resulted in harm to resident #1. This information was confirmed by the administrator. The staff at the facility showed no regard for the welfare of residents by leaving the entire floor and wing of the facility without any staff for an extended period of time, by not responding to the door alarm, by not taking immediate action when a resident was identified as missing, and by not being knowledgeable of the physical features of the building and the facility's systems, including not knowing where [redacted] door [redacted] was located. In addition, the administrative staff and operator's representatives were aware that employees were sleeping on the job, and taking extended breaks outside the facility. Despite this, sufficient action had not been taken to ensure these negligent practices ceased. The operator had not provided the necessary level of supervision required to maintain compliance, as evidenced by the non-compliant issues identified in this endangerment. The facility staff's disregard for resident welfare and safety, and the failure of the operator to provide adequate oversight and supervision, endangered all residents and allowed a situation to occur which caused significant harm to one resident. (NN,GP,RS)	B1085		

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B1085	Continued From page 8 CORRECTIVE ACTION REQUIRED Immediately correct the noncompliant issues cited above. Summarize in the POC text actions taken to correct identified violations. The operator must ensure, through a comprehensive and responsive program of resident services, supervision and management, that the facility is operated in compliance with all the applicable regulatory requirements, including those specifically listed herein. Develop, revise and/or review policies and procedures to ensure continued compliance in the areas identified. Provide staff training and direct oversight and supervision, as warranted, to ensure compliance. Summarize the revised policies and the documentation of training content and attendance in the corrective action plan.. The operator must develop and implement adequate procedures to ensure that sufficient supervision services are provided to all residents, at all times, and as warranted by residents' characteristics, behavior and needs. Such procedures must include specific actions to be taken to ensure that adequate supervision is provided in order to ensure the health and safety of all residents. The operator must ensure that there is sufficient qualified staff onsite during each shift to provide the services required by regulation including resident monitoring and that resident care needs are met. Summarize in the POC text the proposed staffing plan based upon resident needs and building layout. Provide training to all staff regarding the provision of adequate supervision.	B1085		

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B1085	Continued From page 9 Provide sufficient supervision of staff to ensure follow-through on policies and procedures, as well as compliance with regulation, to assure the safety and well-being of residents. Develop, review and/or revise policies and procedures to ensure that residents are evaluated on an on-going basis so that all resident needs are identified and met. In-service staff on these policies and summarize training content. Maintain documentation of training on file for review by surveillance staff. Summarize in the POC text any new policies and/or policy revisions. Develop, review and/or revise a monitoring system through the facility's Quality Assurance Program to ensure continual compliance with New York State regulations. Include title of staff (position) responsible for monitoring for continued compliance. Initiate corrective action when indicated. Designate and indicate in the POC text, the title of the staff (position) that will be responsible for ensuring the completion of the corrective action plan.	B1085		

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B 808	1001.11 (b) Personnel. (b) Unless otherwise stated in this section, the operator shall ensure sufficient staff in number and qualifications to conduct the functions specified for an adult home or enriched housing program as prescribed in Part 487 or 488 of Title 18 NYCRR, respectively. This LICENSURE is not met as evidenced by: Based on a review of facility records, employee time cards and facility staff interviews during the complaint inspection on 12/8/17, the facility did not ensure sufficient staffing, as evidenced by the following: Facility staff, including the case manager for the North Unit, stated that the North Unit is staffed with one medication tech and 3 aides on all shifts because of the number of enhanced residents with increased needs on the unit. There were 23 residents identified as EALR (Enhanced Assisted Living Residence) residing on the North Unit. The case manager provided information on the resident needs for this unit and there were 12 residents that required transfer assistance of 1 person, 2 residents requiring transfer assistance of 2 persons, 16 residents that were wheel chair dependent and 6 of the wheel chair dependent residents were not able to self-propel. The facility schedule identified that on 11/5/17, there was one medication tech and 3 aides assigned to the North Unit for the 3:00 p.m. to 11:00 p.m. shift. The employees' time cards identified that employee #2 left the facility at 9:20 p.m., employee #3 left at 11:03 p.m., employee #4 left	B 808	A review of the assisted and enhanced levels of all residents in the building has occurred, and the guidelines used to identify those needs has been reviewed and revised. A list of the residents and their units will be available for review along with the revised form used to determine care. Per DOH guidelines, based upon a full census, minimum staffing should be eight staff. Brompton Heights will exceed these guidelines due to the layout of the building and to make sure call bells are answered within a timely manner. Minimal scheduled staff in the building will be 12 during the a.m. and p.m. shifts. During overnight shifts minimal scheduled staff in the building will be 7 -8 depending on the then current census. All those on call and those who handle scheduling will be in-serviced on the minimum scheduled staffing levels by 3/1/18. Periodically, a review of the staffing levels will take place by the case managers and/or administrator and/or director of personal care to make sure staffing is still appropriate based upon care and number of residents in the building. In addition, a designated Manager On Duty 24/7 has been implemented at Brompton Heights whenever possible. This person consistently completes rounds of the facility and is a point of contact for staff, families and in emergency situations. Staff have been trained and informed not to leave the unit they are assigned to unattended, including staggering breaks and waiting for the next shift coverage to arrive, at staff meetings on 1/4/2018 and 2/9/2018 as well as in a letter attached to their paycheck in December 2017. This information has been added to a training	03/19/2018

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B 808	Continued From page 1 at 9:26 p.m. and employee #7 left at 11:00 p.m. Employee #6 stated that employee #3 had permission from her supervisor to leave early (before 11:00 p.m.) and prior to leaving, employee #3 gave report to employee #6 and requested that employee #6 assist a resident on the North Unit with bedtime care around 10:00 p.m. Employee #6 stated that when arriving on the North Unit at approximately 10:10 p.m., there were 5 or 6 resident call lights alarming and there were no other employees observed on the North Unit. Employee #5 stated that she had observed from another unit that there were multiple resident call bells alarming on the North Unit and went to the North Unit and assisted employee #6 in responding to 5 or 6 resident call bells. Employee #5 confirmed that while on the North Unit helping employee #6, she did not observe any other employees. Employee #5 stated that she could recall this evening quite clearly because there was a family member on the unit who was very upset, verbalizing that there had not been any staff observed on this unit for almost 30 minutes. Based on the time cards, employees #3 and #7 were in the facility until approximately 11:00 p.m.; however, employee #7 was not observed on the North Unit and employee #6 stated that employee #3 left the facility early with permission from the supervisor. The time clock system used by this facility has a plastic card for each employee, identified by employee name, on a wall board directly adjacent to the time clock. Facility staff select their time card and clock in and out using the time clock system. It could not be determined why, on 11/5/17,	B 808	tool for new hire aides and nurses that will go into place beginning 3/19/2018 and for all current staff beginning 3/5/2018.	

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	AF0460A	A. BUILDING _____ B. WING _____	01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROMPTON HEIGHTS	275 BROMPTON ROAD WILLIAMSVILLE, NY 14221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 808	Continued From page 2 employee #3's time card was clocked out at 11:03 p.m. when faciltiy staff stated that this employee left early or the whereabouts of employee #7 from approximately 9:50 p.m. until 10:30 p.m. (BW) CORRECTIVE ACTION REQUIRED The facility must be sufficently staffed to answer resident call bells and to meet the residents' needs in a timely manner. When permitting facility staff to leave early, the supervisor must ensure that each unit remains adequately staffed and supervised. Summarize in the POC text the actions that the facility will implement and maintain to ensure call lights are responded to, resident needs are met and that each unit is consistently supervised by staff.	B 808		
B 904	1001.12 (b) (1-7) Records and Reports. (b) The operator must maintain complete, accurate and current personal records for each resident which must be available for review and inspection by Department staff or designees and which contain at a minimum: (1) personal data, including identification of the resident's next of kin, family or resident's representative, legal representative, if any, and the name and address of the person or persons to be contacted in the event of an emergency; (2) medical evaluations and other medical information; (3) health care proxy or other advance directives, if applicable;	B 904	The identified resident records will be updated to include needed areas of: admission decision, documents provided on admission, signatures of resident and others participating, and signature of representative. The sales and case management team were re-trained in regard to this on 2/6/18 as to the importance of thoroughness when completing admission documentation. An in service took place on 2/9/2018 to address when and how to complete progress notes and incidents reports in regard to behaviors as well as documenting and explaining why residents were sent to the hospital.	02/09/2018

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B 904	Continued From page 3 (4) pre-admission evaluation and subsequent functional and social evaluations; (5) individualized service plans; (6) medication assistance record; and (7) case management notes which include details of referrals, service coordination and such other correspondence and papers as are available to document the activities undertaken to meet the resident ' s needs. This LICENSURE is not met as evidenced by: Based on a review of 5 resident records and interviews with staff during the complaint inspection on 12/14/17, 12/15/17 and 12/18/17, the operator did not ensure that resident records were complete, as evidenced by the following: - The pre-admission interview for resident #1 did not include the admission decision, documents provided on admission, and the signature of the resident and/or resident representative or others participating. In addition, on [redacted]17, a progress note indicated that the resident's [redacted] was increased due to the resident's behavior; however, there was no documentation of any behaviors in the resident's record until [redacted]17. - The pre-admission interview for resident #2 did not include documents provided on admission or others participating. - The pre-admission interview for resident #3 did not include the admission decision, documents provided on admission, and signature of the resident and/or resident representative or others	B 904		

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B 904	Continued From page 4 participating. - The pre-admission interview for resident #4 did not include the admission decision, documents provided on admission, and signature of the resident and/or resident representative or others participating. In addition, on [redacted]/17, a progress note indicated that the reisdent was sent to the hospital by the [redacted] nurse; however, there was no documentation that explained why the resident was sent to the hospital. (SP) CORRECTIVE ACTION REQUIRED Update the above cited resident records to include all missing information. Review all resident records to ensure all records are complete, current and accurate. Summarize in the POC text all steps taken to correct this violation and ensure continued compliance.	B 904		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
B 908 SS=A	1001.12 (c) (3) Records and Reports.

(c) The operator must maintain complete, accurate and current program records which document operation and maintenance of the assisted living residence with applicable law and regulations, including but not limited to:

(3) a personnel record for each employee which includes, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for the duties assigned; signed and dated applications for employment; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data, provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessments shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given personal records of residents, and provided that the operator shall have access to such personnel records for all staff of contractors who provide services to residents; and

This LICENSURE is not met as evidenced by:

The physician's statement and documentation of a ppd were not on file for employee #1. (SP)

C1958 SS=A 487.7 (d) (11) Resident Services

(d) Supervision.

(11) The operator must prepare an incident report (DSS-3123) whenever:

(i) a resident's whereabouts have been unknown for more than 24 hours;

(ii) a resident assaults or injures, or is assaulted or injured by another resident, staff or others;

(iii) a resident attempts or commits suicide;

(iv) there is a complaint or evidence of resident abuse;

(v) a resident dies;

(vi) a resident behaves in a manner that directly impairs the well-being, care or safety of the resident or any other resident or which substantially interferes with the orderly operation of the facility;

(vii) a resident is involved in an accident on or off the facility grounds which results in such

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	02/28/2018

New York State Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
C1958	Continued From page 1 resident requiring medical care, medicare attention or services; or (viii) it is believed that a felony crime may have been committed by or against a resident. This LICENSURE is not met as evidenced by: Incident reports were not completed for the following: - On [redacted]17, resident #1 [redacted] staff into the hall and was [redacted] with a visitor. After the visitor left, the resident continued to [redacted] - On [redacted]17, resident #4 fell and was sent to the hospital, and on [redacted]17, the resident became [redacted] with staff, and [redacted] (SP)
C3550 SS=A	487.10 (d) (5) Records and Reports (d) Facility records. (5) At a minimum, the operator shall maintain: (i) individual resident records as stipulated in subdivision (c) of this section; (ii) resident records stipulated elsewhere in these regulations, including daily census reports and incident reports; (iii) a chronological admission and discharge register, consisting of a listing of residents registered in and discharged from such facility by name, age, sex of resident, and place from or to which the resident is registered or discharged; (iv) program records, including service procedures, activities schedules, agreements with external service providers, emergency plans and records of evacuation drills; (v) food service records, including menus and food purchase records; (vi) records of maintenance of the physical plant and environmental standards; (vii) staff records, including personnel procedures, job descriptions, staffing schedules and payment records; (viii) certificates or reports issued by local and other State jurisdictions related to the facility operations, on file and readily accessible for department review, or posted, if required; and

New York State Department of Health

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
C3550	Continued From page 2

(ix) records documenting the development, implementation and, at a minimum, the bi-annual updating of quality assurance activities for each area of facility operation. These must include, at a minimum, the development and maintenance of performance standards, measurement of adherence to such standards and to applicable state and local laws and regulations, identification of performance failures, design and implementation of corrective action.

This LICENSURE is not met as evidenced by:

- Resident #5 was not on the current resident roster and was not listed as a discharge on the admission discharge register, although the daily census report indicated the resident had been discharged on [redacted]/17.

- The [redacted]/17 entry in the admission discharge register for resident #6 did not indicate whether the resident was being admitted to the facility or discharged. (SP)